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ABSTRACT

The expanding population of older women relative to older men or the "feminization of aging" is a significant demographic trend with important implications for the future. Older women are at risk for extended years of widowhood, living alone, institutionalization, poverty, and mental health problems. Although the dementias of late life appear to affect men and women equally, women who develop Alzheimer's disease or related disorders seem more likely to be abused by their caregivers. Women are more likely than men to be primarily responsible for the care of a relative with dementia. Life transitions such as death or illness, and interpersonal losses or conflicts in the caregiving role may be accompanied by depression. The highest incidence of alcoholism in women occurs in widows, and among older women it is the second most common cause for admission into a psychiatric hospital. Women are also likely to be frequent and steady users of psychotropic drugs. The attitudes and biases of mental health professionals are barriers to effective health care for older women, and labor and health care policies have a direct impact on the accessibility and the quality of health care for older women. Society must work to meet the inherent demands of widespread gains in longevity, particularly among women, and to prepare for the changing needs of succeeding age cohorts. This requires an immediate response to ageist and sexist practices detrimental to women and men, both young and old. Research is needed to examine exigencies of the older population and to build sound policy for implementation. Potentially the effects could be far-reaching, influencing future generations. (NRB)

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OLDER WOMEN: A POPULATION AT RISK FOR MENTAL HEALTH PROBLEMS*

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This paper presents an overview of the mental health needs of older women, the feminization of aging, and suggestions for labor and health policy changes necessary to provide optimal mental health care. Women face special psychological and psychosocial problems as they grow older and appear to be at increased risk for certain forms of psychopathology. Sociopolitical influences throughout the lifespan, age shifts in the population demography, the longer life of women, and other factors create special burdens for older women, especially the old-old and extreme aged.

Key Words: Feminization of aging, Alzheimers disease, Depression, Alcohol and drug abuse, Labor and health care policies.

Women and men are living longer, and, regardless of sex, face a series of challenges to maintain a lifestyle which promotes health and a quality of life worth living. Aging has been called the great bittersweet success of our century (Eisdorfer, 1983), and the complex implications of a changing age demography are just beginning to emerge. Every domain of life is being affected -- health care, housing, work and leisure, transportation, education, as well as the quality of individual and family life. Indeed, the moral fabric of our culture is being challenged to acknowledge the inherent value of the aging and the aged.

The purpose of this paper is to selectively review some of the current demographic trends as well as the special mental health problems older women may face. Our analysis is not based on the assumption that older women and men necessarily fall into two distinct or exclusive groupings, but rather that there are different demographic trends and developmental challenges for each sex.

With few exceptions women have always outlived men. The 1980 U.S. Census Bureau statistics showed a seven-and-a-half year difference in life expectancy favoring women with a predicted ten year difference by the turn of the century. Currently, there are 16.4 million older women

or approximately sixty percent of the population age sixty-five and older (Rix, 1984; Warlick, 1983). In the fastest growing age group, eighty-five years and older, women outnumber men more than two to one (Porcino, 1983). This expanding population of older women relative to older men or the "feminization of aging" is a significant demographic trend with important implications for the future. Several patterns emerge: Older women are at risk for extended years of widowhood, living alone with increasing frailty, institutionalization when they become disabled, and a disadvantaged financial status.

Since women are outliving men, it is not surprising that the majority of older women are widowed or living alone (Bumagin and Hirn, 1982; Rix, 1984). At age 65 and over, 75% of men have a spouse living with them as compared to 37% of women (Rhodes, 1982). At age 75 and over only 20% of women have a spouse living with them and over 50% live alone as compared to 27% of men (Rhodes, 1982). Older black and Hispanic women are significantly more likely than white women to be living without a spouse but are also more likely to be living with others (Rix, 1984). Finally, older women are twice as likely as older men to reside in nursing homes and account for 73% of the older institutionalized population (Vital and Health Statistics, 1978; Rix, 1984).

Despite their widowhood older women maintain affiliative relationships in late life which may in part be a function of the larger numbers of older women. A 1974 national survey showed that older widows maintained contact with friends in contrast to widowers who spent less time socializing with friends (Arens, 1982, 1983). Women who have been married at some point in their lives appear to be more advantaged than women who have remained single. Longino & Lipman (1982) studied the family and social support systems of older women and observed that women who were married received significant emotional, social, and instrumental support from family members. The presence of a living husband only accounted for more instrumental or task - oriented support. The greatest amount of emotional and social support came from children.

Women have more serious financial problems than men in late life. A significant percentage of black, Hispanic, and white women have incomes below the currently defined poverty level, 43.5% 27.4% and 16.2% respectively (Vital and Health Statistics, 1978). This accounts for approximately 17% of older women or 10% of the U.S. population defined as poor (Estes et al., 1984; Rix, 1984). Therefore, women comprise 72% of the aged poor and are twice as likely as men to experience poverty in old age (Rix, 1984; Warlick, 1983).

Growing old and female is a personal challenge of daring and endurance. Older women are becoming a visable and expanding segment of the population. They have special problems and present a challenge to policy makers and other professionals in the fields of aging and mental health. Although both men and women must confront the inevitable and mounting interpersonal losses associated with growing older, women, because of their increased longevity must cope longer.

Alzheimers Disease and Related Disorders

Issues related to the etiology, diagnosis, and treatment of progressive dementia will not be discussed here, but are reviewed elsewhere (Cohen, 1982; Cohen and Eisdorfer, 1984; Eisdorfer and Cohen, 1978). In this section we will review two problems which confront older women. First, although the dementias of late life appear to affect men and women equally, women who develop Alzheimers disease or a related disorder seem more likely to be abused by their caregivers. Second, women are more likely than men to be primarily responsible for the care of a relative with dementia.

Women are at risk whether they are patients or "care-receivers." Women who are care-receivers are more likely to live longer and suffer from abuse and neglect. Blessed and Wilson (1982) observed that very old women with dementia survive longer than men, and a study conducted at the

Chronic Illness Center in Ohio suggests that older women are vulnerable to abuse (Lau and Kosberg, 1979). The sample of abused clients age 60 and over was 75% female and among the total abuse cases 41% were "partially or totally confused."

Caring for patients with Alzheimers disease and related disorders imposes an enormous financial and emotional burden on family caregivers (Noelker, 1984; Zarit et al., 1980). Community surveys and clinical studies alike reveal that approximately half of primary caregivers, i.e. persons living with the patient and providing daily care, suffer from depression, emotional distress, and/or physical illness. (Cohen and Eisdorfer, 1984; Noelker, 1984). While caring for cognitively impaired patients is stressful for everyone, women of all ages, whether spouse, adult daughters or daughter-in-laws, are more often in the role of primary caregiver (Rhodes, 1982; Shanas, 1979; Townsend, 1969). In a survey of older day care participants 70% were cared for primarily by a female family member (Crossman et al., 1981). However, this pattern may change in the future if the growing number of men in dual-career couples involved in childcare activities reach old age and assume more involvement as caregivers.

Spouses generally manifest higher levels of care-related distress relative to other family members because they are living with little respite. Older women report feeling

conflict about competing demands between their caregiving responsibilities and roles as workers, homemakers, wives, mothers, and grandmothers (Brody and Brody, 1981). The responsibilities of caring for older relatives occurs at a time in life when many older women face changes such as the onset of chronic ailments, interpersonal losses, financial difficulty, and expectations of increased leisure time during the retirement years.

The conceptual and empirical studies of Gilligan (1982) suggest that women may be psychologically more capable than men of balancing competing needs in caring relationships. Gilligan proposes that women develop and maintain strong affiliations with other people in contrast to men who are more oriented to individualized lifestyles and personal achievement rather than caring relationships. Consequently, caring roles have greater psychological meaning for older women compared to men, i.e. men are less vested in an ethics of care. Her theory would predict that if women are not able to resolve their dilemmas about conflicting responsibilities to multiple relationships, they are at risk for depression and emotional distress.

Depressive Disorders

Depression occurs throughout the lifespan, but in every age group the rates of clinical depression are higher for

women than for men (Weissman and Klerman, 1981). Data collected in the U.S. between 1936 and 1973 show a consistent sex ratio for depressive disorders - approximately 2 women to each 1 man (Weissman and Klerman, 1981). Information on suicide attempts from Australia, Great Britain, the United States, and Israel also reveal a 2:1 sex ratio of women to men (Weissman and Klerman, 1981). Russo and Olmedo (1983) surveyed clients admitted to outpatient psychiatric facilities during 1975 and found that 11.6% of white women and 32% of black women age 65 and over were diagnosed as depressed compared to 5.7% of white men age 65 and over. There were too few black men in the sample to draw any conclusions, perhaps reflecting the shorter life expectancy of black males.

Weissman and Klerman (1981) have concluded that sex differences in depressive illness are not artifacts of sex differences in reporting stress and distress, nor can they be adequately explained by endocrine changes during the child-bearing and child-rearing years. The apparent higher rate of depression may have psychological explanations. One hypothesis states that depression is the consequence of psychological reactions to social discrimination and inequities endured by women (Weissman and Klerman, 1981). Perceptions of low social status may produce feelings of

powerlessness, dependency, low self-esteem, low aspirations, and ultimately clinical depression. A second and related hypothesis argues that learned helplessness is internalized to produce depression (Seligman, 1974). This may occur in women due to their social conditioning which inhibits assertive behavior and other skills needed to protect against depression. Another theory (Gilligan, 1982) predicts that feelings of self-worth in women are tied to a sense of connectedness in relationships and an identity as a caregiver. The latter theory has far-reaching implications for the older woman. Life transitions such as death, illness, and interpersonal losses or conflicts in the caregiving role may be accompanied by depression. Research is necessary to understand how older women cope successfully or unsuccessfully with life transitions and stress and to identify behavioral and social risk factors for depression.

Alcohol and Drug Abuse

The prevalence of alcoholism among the aged is comparable to the general population (Zimering and Domeischel, 1982). In 1978 the National Institute on Alcohol Abuse and Alcoholism (NIAAA) issued a report stating that 2% of women over age 60 years compared to 10% of men age 60 years and older were problem drinkers. However, women were more likely to be frequent and steady users of psychotropic drugs (Cooperstock,

1976). Every year 75% of women age 65 and over are prescribed mood-altering drugs (Porcino, 1983).

The highest incidence of alcoholism in women occurs in widows, and among older women it is the second most common cause for admission into a psychiatric hospital (Porcino, 1983). Women alcoholics are more likely to be deserted by their spouses than are their male counterparts (Porcino, 1983).

Older women who are chemically dependent may face significant barriers to treatment. Alcoholism carries a social stigma, and unfortunately diagnosis of the problem may be difficult because families or older women themselves try to hide the problem. Physicians and health professionals must also be able to examine their own attitudes and practices that might interfere with being able to ask questions, diagnose, and treat an alcohol or a drug problem. Changes in attitudes as a result of education about alcoholism and the role of women in our society are germane to quality treatment and prevention. It is tragic for a person suffering from alcoholism not to receive treatment. Alcoholism leads to many problems, e.g., depression, dementia, cancer, gastritis, etc.

Effective care for the older alcoholic woman consists of both medical care and psychosocial services. Notable non-medical treatment programs include Alcoholics Annonymous which has a growing membership of women and Women for Sobriety, a national network of groups geared to the alcoholic woman (Sandmaier, 1980).

Barriers to Care for Mental Health Services

The attitudes and biases of mental health professionals are barriers to effective health care for older women. A report by Levine et al., 1974 showed that in North America 90% of psychiatrists, 66% of clinical psychologists, and 40% of social workers are male. These figures clearly demonstrate a disproportionate number of male practitioners among the more influential levels of mental health professionals. There is also some evidence to suggest that clinicians have different standards of mental health for the sexes and pose a double-bind for women. Broverman and colleagues (1970) administered a questionnaire to male and female clinicians designed to elicit their clinical judgments of a healthy adult, as well as a healthy man and a healthy woman. The clinicians agreed that the traits of healthy men did not differ significantly from healthy adults, whereas there was a significant difference between judgments in what constitutes a healthy woman compared to a healthy adult.

Women are prescribed 2½ times as many psychotropic drugs as men (Cooperstock, 1976), a difference which cannot be explained by the greater number of visits women make to physicians. Although women receive more prescriptions for all classes of drugs, psychotropic medications ranked

highest. In long term care facilities women receive more psychotropic prescriptions relative to men, even when diagnostic categories are held constant (Milliren, 1977).

Women are more frequently seen in outpatient services. A 1975 National Institute of Mental Health survey showed that 60% of admissions between the ages of 18 and 65 were women (Russo [illegible] medo, 1983). Although individuals over age 65 were c[illegible] small percentage of the total outpatient population (11%), women again outnumbered men about 2:1.

Service utilization is affected by many factors including the accessibility and availability within the health care system. For example, a study by the New York State Commission on Women found that in 45 inpatient alcohol facilities in the state, only 17% of the beds were allocated for women (Gillen, et al, 1977). As a result women were placed on waiting lists or had to travel significant distances to find an appropriate program.

Impact of Labor and Health Care Policies on Older Women

Labor and health care policies have a direct impact on the accessibility and the quality of health care for older women. Potential sources of income f[illegible] older women are affected by marital status and may include personal assets, employer pension plans and retirement benefits, as well as income from public programs such as Social Security, Supplementary Security Income (SSI), Medicare, and Medicaid.

Men typically have greater assets to purchase health care than women as a result of forces operating in the labor market where women on the average earn only 60% of men's wages (Estes et al., 1984). For women age 65-69 years the median income in 1977 was less than 50% of men's median income (U.S. Bureau of the Census, 1980). For divorced women alimony is an unreliable asset since only 46% of women age 40 and over awarded alimony receive any payment (Current Population Report, 1981).

Women are much less likely than men to be covered by retirement plans as a result of their overrepresentation in the secondary labor market, i.e., low-paying jobs with instability and poor working conditions. Private pensions are not available to cover 80% of retiring women workers (White House Conference on Aging, 1980). Furthermore, it was not until 1983 that it became illegal for employers to pay women retirees at lower rates based upon women's greater longevity despite equal contributions to pension plans (Estes, et al., 1984). Both older women and men are prevented or discouraged from remaining in the labor market through superannuation or retirement and the reduction of Social Security benefits. For women this means a longer retirement period with an associated drop in income.

Social Security is the major source of income for the majority of older women, but women only receive [illegible] of the amount men receive (U.S. Senate Special Committee on Aging, 1975). There are several reasons for this. The pay differential in the labor market is one factor that leads to lower Social Security benefits for older women (Estes et al., 1984). Time spent out of the paid labor market for homemaking and childcare activities is also included in the averaging period used to compute benefits, which lowers their average benefits compared to men (Estes, Gerard, and Clarke, 1984). Social Security benefits prior to 1975 were computed on outdated earnings eroded by an inflationary economy (Estes et al., 1984; Rix, 1984). There are disincentives to work for the lower wage earner (usually women) of a two-earner couple, and the surviving spouse of a two-earner couple (usually women) receive less than the surviving spouse of a one-earner couple with the same total earnings (Estes et al., 1984). Finally, women dependent on their husband's retirement benefits may face a long gap in protection if their spouse dies prior to early retirement (Estes et al., 1984; Rix, 1984).

Medicare covers approximately 44% of an older person's health care expenses, but Medicare places older women at a disadvantage for several reasons: 1) It does not cover

individuals who do not qualify for Social Security benefits (generally women); 2) It focuses on acute illnesses while most older women have chronic illnesses not requiring hospitalization; and 3) It may force women to accept hospital care as a prerequisite to receiving financial reimbursement (Porcino, 1983). Furthermore, if an older woman's spouse requires long-term care her financial options are limited. These include "spending-down" until they are pauperized and therefore eligible for Medicaid, divorce, or assuming the role of primary caregiver to prevent institutionalization (Estes et al., 1984).

Thus, health care related policies have a major impact on the quality and accessibility of medical care for older women. Our current health care system is excessively reliant on hospital or institutional services where community care alternatives may suffice. Current policies also undercut the "informal caregiver" unduly stressing the "family" which in most cases are older women. This has serious repercussions in terms of financial impoverishment, physical and emotional health, and other negative effects of caregiving.

SUMMARY

The United States is undergoing a changing age structure in which the fastest growing segment of the population, those over age 65, is increasingly peopled by older women with the most dramatic sex differences among the extreme aged. Predictably, with advancing age, older women are more likely to confront poverty, widowhood, living alone, institutionalization, and chronic multiple illnesses including the risk of mental health problems. Society, too, faces the pressing impact of a rapidly expanding aged population on the economy, health care system, and family.

The current challenge is twofold: to meet the inherent demands of widespread gains in longevity, particularly among women, and to prepare for the changing needs of succeeding age cohorts. This requires an immediate response to ageist and sexist practices detrimental to women and men, both young and old. Research is needed to examine exigencies of the older population and to build sound policy for implementation. Potentially the effects could be far-reaching, influencing future generations.

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